LAW OFFICES OF

DUKES, DUKES, KEATING & FANECA, P.A.

2909 13TH STREET, SIXTH FLOOR
GULFPORT, MISSISSIPPI 39501

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WILLIAM F. DUKES,
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GULFPORT, MS 39502

TELEPHONE
228-868-1111

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228-863-2886

February 22, 2008

VIA FACSIMILE - (865-0337) and U.S. Mail
Michael Crosby, Esq.
2111 25th Avenue
Gulfport, MS 39501

Re: Roderick Clark Miller v. Harrison County, Mississippi, et al.
U. S. District Court, Southern District of Mississippi, Southern Division
Civil Action No. 1:07cv541
Our File No. 1811.0108

Dear Michael:

In our Requests for Production of Documents which were propounded to you on October 15, 2007, we requested the Plaintiff to execute the following:

1. Request for Copy of Tax Return,
2. Request for Social Security Earnings Information,
3. Authorization for release of employment records, and
4 Authorization for health information.

I am enclosing herewith additional copies of same. Please have your client execute same and return to our office within the next five calendar days.

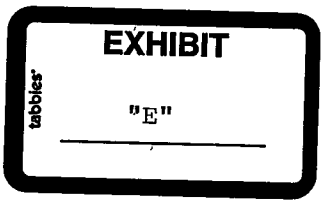
Sincerely,

DUKES, DUKES, KEATING & FANECA, P.A.

Cy Faneca

Cy Faneca

CTF:lh
Enclosures



cc: John Whitfield
Jim Davis
Karen Young
George Hembree, III

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize _____ to use or disclose the following protected health information (PHI) from the medical records of the patient listed below to:

Requestor Name: Dukes, Dukes, Keating and Faneca, P.A.
P.O. Drawer W
Gulfport, MS 39502

Patient Name: Roderick Miller
Patient DOB: _____
Patient Social Security Number: _____
Patient Address: _____

Disclose the following PHI for treatment dates _____ to Present.

☒Abstract/Pertinent	☒History and Physical	☒Physician Orders	☒Entire Chart
☒Operative Report	☒Progress Notes	☒X-ray	☒Billing
☒ER Report	☒Lab	☒Consult	
☒Other specified	☒Discharge Summary	☒Nurse Notes	

☒Other Specified: All other such records in your possession, custody or control.

The above information is disclosed for the following purposes:
☐Medical Care ☒Legal ☐Insurance ☐Personal ☐Other

____ *initials* I acknowledge, and hereby consent to such, that the release of information may contain alcohol and drug abuse, psychiatric, HIV or genetic information

This authorization shall expire upon this expiration date: final disposition of **Roderick Miller v. Harrison County Sheriff's Department, et. al** or five (5) years from the date of this authorization, whichever comes first
**If I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

- I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present the written revocation to _____. I understand that the revocation will not apply to information that has already been released to this authorization.
- The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected.

I have read the above and authorize the disclosure of the protected health information as stated. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.

_____ _____
Signature of Patient/Legal Representative Date

If signed by legal representative, relationship to patient: _____

_____ _____
Signature of Witness Date

AUTHORIZATION FOR RELEASE OF PSYCHOTHERAPY NOTES

Name: **Roderick Miller**

Date of birth:

Social Security Number:

I hereby authorize all health care providers, physicians, hospitals, clinics and institutions, medical facilities, mental health clinics, mental health hospitals, pharmacies, Social Security Administration Disability Determination Services and Department of Workers' Claims, to release all psychotherapy note records and information regarding _____, to the records service of _____.

I understand that this authorization is for release of psychotherapy notes as defined by the Health Insurance Portability and Accountability Act 45 CFR 164.501 *[psychotherapy notes means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's record].*

I, the undersigned individual am on notice that:

1. Initiating this request for disclosure of protected health information, and any disclosure of the same pursuant hereto is at the request of the individual.
2. Any health care provider disclosing the above requested information may not condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.
3. This authorization can be revoked through written notice to _____ _____, or to the individual above listed entities, except to the extent that action has been taken in reliance on this authorization. The undersigned is aware of the potential that protected health information disclosed pursuant to this authorization is subject to re-disclosure in a manner that will not be protected by HIPAA regulations.
4. A photocopy of this authorization shall be considered as effective and valid as the original, and this authorization will remain in effect until settlement or final disposition of _____vs. _____ or five (5) years from the date of this authorization, whichever comes later.

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Date: _____ _____

(Signature) Patient or Patient Representative

_____ _____

Printed Name of Patient's Representative Relationship to Patient

_____

Description of Representative's Authority to Act for the Patient

This authorization is designed to be in compliance with the Health Insurance Portability and Accountability Act ("HIPAA") 45 CFR Parts 160 and 164.

**Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress date.*

EMPLOYMENT AUTHORIZATION

TO WHOM IT MAY CONCERN:

This authorizes any employer by whom I have been employed or sought employment, any labor union of which I am or have been a member, and any state or federal employment agency or commission, to furnish full and complete information hereby requested to the law offices of Dukes, Dukes, Keating and Faneca, P.A., or to any representative, attorney, or investigator from said office, including all employment information, employment applications, personnel files, information pertaining to my wages, and other related matters.

I hereby agree that a copy of this authorization form shall have the same force and effect as the original thereof.

Your full cooperation with the said attorneys is requested. You are further requested to disclose no information to any other person without written authority to do so.

ALL PRIOR AUTHORIZATION IS HEREBY CANCELED.

_____

Roderick Miller

Social Security Number: _____

Date of Birth: _____

Form **4506**

(Rev. April 2006)

Department of the Treasury
Internal Revenue Service

Request for Copy of Tax Return

▶ **Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.**

▶ **Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.**

OMB No. 1545-0429

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T**, Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b **First social security number on tax return or employer identification number (see instructions)**
2a If a joint return, enter spouse's name shown on tax return	2b **Second social security number if joint tax return**

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code

4 Previous address shown on the last return filed if different from line 3

5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.
Cy Faneca, Dukes Dukes Keating & Faneca, PA, P.O. Drawer W, Gulfport, MS 39502
Telephone: 228-868-1111

Caution: *If a third party requires you to complete Form 4506, do not sign Form 4506 if lines 6 and 7 are blank.*

6 **Tax return requested** (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. ▶ 1040
Note. *If the copies must be certified for court or administrative proceedings, check here.* . . . . . ☐

7 **Year or period requested.** Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

12 / 31 / 02	12 / 31 / 03	12 / 31 / 04	12 / 31 / 05
12 / 31 / 06	/ /	/ /	/ /

8 **Fee.** There is a $39 fee for each return requested. **Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.**

a	Cost for each return	$ 39.00
b	Number of returns requested on line 7	
c	Total cost. Multiply line 8a by line 8b	$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here . . ☐

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, **either** husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

Sign Here	▶ Signature (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a ( )
	▶ Title (if line 1a above is a corporation, partnership, estate, or trust)		
	▶ Spouse's signature	Date	

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

   Print the Name, Social Security Number (SSN), and date of birth below.

   Name _____ Social Security Number _____

   Other Name(s) Used (Include Maiden Name) _____ Date of Birth (Mo/Day/Yr) _____

2. What kind of information do you need?

   ☐ **Detailed Earnings Information** (If you check this block, tell us below why you need this information.) For the period(s)/year(s): _____

   _____

   _____

   ☐ **Certified Total Earnings For Each Year.** (Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement) For the year(s): _____

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 . . . . . A. $ _____

   Do you want us to certify the information? ☐ Yes ☐ No

   If yes, enter $15.00 . . . . . B. $ _____

   ADD the amounts on lines A and B, and enter the TOTAL amount . . . . . C. $ _____

   - You can pay by CREDIT CARD by completing and returning the form on page 4, or
   - Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payble to "Social Security Administration"
   - DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than $5,000 or one year in prison.

   SIGN your name here (Do not print) > _____ Date _____

   Daytime Phone Number _____ _____ (Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

   Name _____ Address _____

   City, State & Zip Code _____

6. Mail Completed Form(s) To:

   Social Security Administration
   Division of Earnings Record Operations
   P.O. Box 33003
   Baltimore Maryland 21290-3003

   Exception: If using private contractor (e.g., FedEx) to mail form(s), use:

   Social Security Administration
   Division of Earnings Record Operations
   300 N. Greene St.
   Baltimore Maryland 21290-0300

****
*** TX REPORT ***
****

TRANSMISSION OK

TX/RX NO	0625
RECIPIENT ADDRESS	8650337
DESTINATION ID	
ST. TIME	02/22 15:21
TIME USE	00'55
PAGES SENT	7
RESULT	OK

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